

**OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM****MEDICAL HISTORY UPDATE FORM**

(See Form ARS-182A/B for Privacy Act Notification)

A record of what has happened **since your last USDA/ARS examination** is very important. Please complete this confidential questionnaire by placing a check mark (*T*) in the appropriate spaces or printing other information where requested. (Use black or blue ink.)

**SECTION 1 – IDENTIFICATION**

1. NAME (Last, first, middle initial)	2. SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	3. SOCIAL SECURITY NUMBER	4. DATE OF BIRTH
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5. CURRENT MAILING ADDRESS (Where confidential mail can be delivered)

6. WHAT YEAR DID YOU START WORK WITH USDA/ARS?	7. HAS THE FOLLOWING INFORMATION CHANGED SINCE YOUR LAST EXAMINATION: <input type="checkbox"/> JOB TITLE/SERIES <input type="checkbox"/> WORK LOCATION <input type="checkbox"/> HOME ADDRESS
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7A. NEW JOB TITLE/SERIES:

7B. NEW WORK LOCATION:

**SECTION 2 – MEDICATIONS**

LIST ALL MEDICATIONS YOU CURRENTLY TAKE (Including prescription, non-prescription, vitamins and herbal preparations)


**SECTION 3 – SOCIAL HISTORY**

1. HAVE YOU EVER USED TOBACCO? ☐ YES ☐ NO  
IF YES: ☐ CURRENT ☐ PAST YEARS SINCE QUITTING? \_\_\_\_\_  
WHAT TYPE: ☐ CIGARETTE ☐ PIPE/CIGAR ☐ SNUFF/CHEWING  
AMOUNT PER DAY? \_\_\_\_\_ HOW MANY YEARS? \_\_\_\_\_

2. WHAT IS YOUR AVERAGE ALCOHOL CONSUMPTION IN A WEEK (one drink = 12 oz. beer or one glass of wine or 1.5 oz. liquor)?  
\_\_\_\_\_ HOW OFTEN DO YOU DRINK ALCOHOL?  
DRINKS ☐ WEEKDAYS ☐ WEEKENDS ☐ BOTH

**SECTION 4 – MEDICAL HISTORY** (Since your last USDA/ARS exam)

HAS YOUR DOCTOR DIAGNOSED YOU WITH ANY OF THE FOLLOWING CONDITIONS?

☐ ALLERGIES (specify): \_\_\_\_\_

<input type="checkbox"/> ANEMIA	<input type="checkbox"/> HERNIATED DISC
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> CLAUSTROPHOBIA	<input type="checkbox"/> KIDNEY DISEASE
<input type="checkbox"/> COLLAPSED LUNG	<input type="checkbox"/> MIGRAINES
<input type="checkbox"/> DIABETES	<input type="checkbox"/> POSITIVE SKIN TEST FOR TB
<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> PROSTATE PROBLEMS
<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> RUPTURED EAR DRUM
<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> SEIZURES
<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> THYROID TROUBLE
<input type="checkbox"/> OTHER MEDICAL DISORDERS (specify): _____	

**SECTION 5 – HOSPITALIZATIONS** (Since your last USDA/ARS exam)

INCLUDE ANY OUTPATIENT SERVICES/PROCEDURES.

YEAR	REASON

**SECTION 6 – OCCUPATIONAL HISTORY** (Since your last USDA/ARS exam)

1. HAVE YOUR JOB EXPOSURES/DUTIES CHANGED? ☐ YES ☐ NO  
IF YES, DESCRIBE: \_\_\_\_\_

2. HAVE YOU HAD ANY INJURY/ILLNESS WHICH YOU THINK MAY BE WORK RELATED? IF YES, DESCRIBE. ☐ YES ☐ NO

**SECTION 7 – REVIEW OF SYSTEMS** (Since your last USDA/ARS exam)

WHICH OF THE FOLLOWING HAVE BEEN A PROBLEM?

GENERAL/CONSTITUTIONAL

- ☐ FEVER > 100  
☐ SHIVERING/CHILLS  
☐ GENERALIZED WEAKNESS  
☐ UNEXPLAINED WEIGHT LOSS/GAIN  
☐ EXCESSIVE FATIGUE  
☐ SWOLLEN GLANDS  
☐ SUDDEN LOSS OF CONSCIOUSNESS  
☐ LOSS OF APPETITE  
☐ HEAD INJURY

HEART/LUNGS

- ☐ CHEST PAIN OR PRESSURE  
☐ IRREGULAR HEART BEAT  
☐ PALPITATIONS/SKIPPED BEATS  
☐ NEW OR CHANGED COUGH  
☐ COUGHING UP BLOOD  
☐ WHEEZING  
☐ SHORTNESS OF BREATH

NEUROLOGIC/PSYCHIATRIC

- ☐ HEADACHES  
☐ DEPRESSION  
☐ NUMBNESS OR TINGLING  
☐ EXCESSIVE ANXIETY  
☐ INSOMNIA/DIFFICULTY SLEEPING  
☐ LOSS OF MEMORY

EARS/NOSE/THROAT

- ☐ DIFFICULTY HEARING  
☐ RINGING, BUZZING  
☐ SINUS TROUBLE  
☐ SNEEZING/RUNNY NOSE  
☐ NOSEBLEEDS  
☐ DIFFICULTY SWALLOWING  
☐ DRY MOUTH  
☐ DIZZINESS

**SECTION 7 – REVIEW OF SYSTEMS (Continued)**

WHICH OF THE FOLLOWING HAVE BEEN A PROBLEM?

GENITOURINARY AND REPRODUCTIVE

- ☐ DIFFICULT OR PAINFUL URINATION  
☐ BLOOD IN URINE

MEN ONLY

- ☐ LUMP IN TESTICLE  
☐ IMPOTENCE

WOMEN ONLY

- ☐ BREAST LUMP/DISCHARGE  
☐ CURRENTLY OR POSSIBLY PREGNANT

DIGESTIVE SYSTEM

- ☐ NAUSEA/VOMITING  
☐ DIARRHEA  
☐ CONSTIPATION  
☐ RECTAL BLEEDING OR BLACK TARRY STOOLS  
☐ YELLOW JAUNDICE  
☐ ABDOMINAL PAIN

EYES

- ☐ CHANGE IN VISION  
☐ ITCHING  
☐ TEARING

SKIN/MUSCULOSKELETAL

- ☐ RASHES  
☐ MOLES THAT CHANGED IN SIZE OR COLOR  
☐ MUSCLE PAIN  
☐ BACK PAIN  
☐ NECK PAIN  
☐ WEAKNESS IN ARMS/LEGS  
☐ JOINT PAIN

TEETH/GUM DISEASE

- ☐ SPECIFY: \_\_\_\_\_

EXAMINER'S COMMENTS (All positive responses in the Medical History (Section 4) and Review of Systems (Section 7) must be clarified here.)

**SECTIONS 8 AND 9 :** The purpose of these sections is to accumulate as much information as possible from ARS employees to determine the existence of clusters or other "sentinel" events that would cause further study. While we realize some of these questions are quite personal, complete information is extremely important and no identifying information will be released.

**SECTION 8 – REPRODUCTIVE HISTORY**

1. HAVE YOU OR YOUR PARTNER EVER HAD A PROBLEM CONCEIVING A CHILD?  
☐ YES ☐ NO

IF YES, SPECIFY: ☐ SELF ☐ PRESENT PARTNER ☐ PREVIOUS PARTNER

2. HAVE YOU OR YOUR PARTNER CONSULTED A PHYSICIAN FOR A FERTILITY OR  
☐ YES ☐ NO

IF YES, SPECIFY WHO CONSULTED THE PHYSICIAN:  
☐ SELF ☐ PARTNER ☐ SELF AND PARTNER

IF YES, SPECIFY THE DIAGNOSIS:

3. HAVE YOU EVER CONCEIVED A CHILD RESULTING IN A (check all that apply):  
☐ DEFORMED OFFSPRING ☐ MISCARRIAGE ☐ STILL BIRTH

IF OUTCOME WAS A DEFORMED OFFSPRING, WHAT WAS THE DEFORMITY?

WAS THIS OUTCOME A RESULT OF A PREGNANCY OF YOURS WITH:

- ☐ PRESENT PARTNER ☐ A PRIOR PARTNER

4. DID THE TIMING OF ANY ABNORMAL PREGNANCY OUTCOME COINCIDE WITH YOUR PRESENT EMPLOYMENT? ☐ YES ☐ NO

LIST DATES OF OCCURRENCES:

5. WHAT IS THE OCCUPATION OF YOUR PARTNER?

**WOMEN ONLY**

6. DO YOU HAVE MENSTRUAL PERIODS? ☐ YES ☐ NO

IF NO, HAVE YOU ENTERED OR COMPLETED MENOPAUSE? ☐ YES ☐ NO

7. HAVE YOU HAD MENSTRUAL IRREGULARITIES? ☐ YES ☐ NO

7A. IF YES, SPECIFY THE TYPE:

7B. DATE BEGAN

7C. DATE ENDED

**SECTION 9 – CANCER HISTORY**

1. HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? ☐ YES ☐ NO

2. DID YOU HAVE SPECIFIC TISSUE DIAGNOSIS (e.g., for skin cancer: basal cell, squamous cell, etc.; for lung cancer: adenocarcinoma, squamous cell carcinoma, "oat" cell, etc.)? If so, complete the following:

DATE DIAGNOSED	CANCER	TISSUE TYPE

EMPLOYEE SIGNATURE

SOCIAL SECURITY NUMBER

DATE COMPLETED